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ABSTRACT

The paper reviews problems encountered by communities serving urban Blacks with serious emotional and behavioral disorders and discusses approaches used in Southside Chicago. Demographic factors affecting provision of service for Black students are detailed. The Illinois Department of Mental Health and Developmental Disabilities has provided funds for psychotherapeutic services at four outpatient programs and six day treatment programs as well as to five mental health centers. Statistics on hospitalization are considered along with information on public school approaches. A collaborative approach in which community owned and operated services are important is emphasized. The spectrum of needed services is viewed in a three echelon model: early treatment and primary prevention; longer term, more intensive treatment; and special long term residential treatment. The need for cooperation and trust among agency workers is underlined. (CL)

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NETWORKING AND DELIVERY OF MENTAL HEALTH AND SPECIAL EDUCATION SERVICES

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NETWORKING AND DELIVERY OF MENTAL HEALTH AND SPECIAL EDUCATION SERVICES

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This paper is part of a panel presentation on Delivery of Services: Networking, Assessment, and Treatment Strategies Applicable to the Education of Black Children who Manifest Serious Emotional, Behavioral or Mental Disorders.

The primary focus here is networking as a crucial component of service delivery. Selected basic demographic data are presented and some principles and strategies pertinent to networking are put forth.

A specific geographic area, the far south side of Chicago, is described to exemplify some of the relevant issues. The area has been designated as Subregion 12 by the Illinois Department of Mental Health and Developmental Disabilities. A comprehensive and detailed description of the Department's activities can be found in its Annual Plan, 1980.

Subregion 12 also comprises most of the geographical area designated for special education services through the Chicago Public School's Pupil Service Center South.

The attempt is not to provide a model or paradigm that should be copied. Rather, the purpose is to point out some factors and techniques that appear to be crucial to the delivery of services to mentally or emotionally disturbed Black children and adolescents.

Mental and emotional disorders are national problems. In 1978, the President's Commission on Mental Health estimated the extent of mental illness and emotional disturbance in children to be fifteen percent of the population.

The Joint Commission on the Mental Health of Children, in 1966, concluded that there was not a single community in the United States that provided an acceptable standard of services for its mentally ill children. With a current estimate of 3,920,000 emotionally disturbed children, it would seem that this remains the case today.

In terms of total numbers, there are more White than Black children who are poor, on welfare, ill educated, and without adequate health care. The needs of Black children and services for them cannot be dealth with in a total vacuum apart from the needs of all children.

However, color and history inextricably bind the fate of all Blacks. To a disproportionate degree Blacks must deal with such factors as unequal and inequitable distribution of wealth and resources. Caste, racism, unequal and inequitable representation in professional and policy-making positions are serious problems.

If services for mentally disordered or emotionally disturbed children and adolescents are generally less than adequate, then the providing of quality services for Black children and adolescents may be even more difficult. In turn, the lack of appropriate services results in a greater cost to society than the cost would be for providing the services.

Full documentation of the preceding points is available from the federal government and such organizations as the Urban League and the Children's Defense Fund.

A few relevant examples follow:

* More than a quarter of all children under 17 lack private hospital and surgical insurance, while more than four-fifths of adults aged 25 to 44 have both.

* Less than 30% of American children are covered through private insurance for out of hospital, physician visits.

* Black children lack private insurance coverage at twice the rate of White children.

* Black children have an infant mortality rate almost twice the White rate.

* Nonwhite mothers die in childbirth three times as often as White mothers.

* A Black male teenager is five times as likely as a White male teenager to be a victim of homicide and is twice as likely to be detained in a juvenile or adult correctional facility.

* Over 10% of all Black mothers receive no prenatal care until the final trimester.

* Only one-sixth of the children eligible for Medicaid get the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services to which they are entitled. These children are disproportionately Black.

* For every 100 students who graduate from high school, 29 drop out. However, there is one Black dropout for every two Black high school graduates.

* In 1976, almost 1.8 million students were suspended from school at least once. At least 1.1 million of them were White; half a million were Black; 90,000 were Hispanic. Yet fewer than 120,000 students were referred to any alternative program to deal with behavioral or discipline problems.

* Black children are more than twice as likely to be suspended from school as are White children; more than twice as likely to be given corporal punishments and three times as likely to be placed in classes for the educable retarded as are White children. The Black child is less than half as likely as a White child to be placed in a gifted class. Moreover, in 1976 with some 2.7 million public school students in special education programs, proportionately twice as many White students were in classes for learning disabled children

as compared to classes for the educable mentally retarded. The reverse was true for Black students.

* Both the absolute and the relative gaps in income for White and Black families are growing.

* The real median income of Blacks fell between 1969 and 1977. The income gap between Blacks and Whites widened by more than 14 percent.

* The proportion of the White poor population has fallen, while the proportion of the Black poor population has grown.

* Children constitute two-thirds of all Aid to Families with Dependent Children (AFDC) recipients. Two out of every five Black children are on AFDC in any one year.

* The national average AFDC payment (typically for a mother and two children) is $241.35 per month. Nationally, this amounts to $83.22 a month, $19.21 a week, and $2.74 a day per person.

* In Illinois, almost 20 percent of the children [48 percent of its Blacks] live in a family headed by their mother.

* About 60 percent of all non-White babies in Illinois are born to unmarried women - a threefold increase in two decades.

* Three out of four Black children and one out of three White children in Illinois will spend at least part of their childhood in a single-parent family.

* Some 19 percent of Illinois residents aged 22 to 35 [35 percent of Blacks and 50 percent of Hispanics] failed to finish high school.

The Chicago Urban League surveyed the number of Blacks in policy-making positions in the Chicago area in 1977. In terms of the Chicago Public School System, department and bureau directors of administrative offices were reviewed. For some eighty policy-making positions, twenty were held by Blacks.

This represents twenty-five percent of the policy-making positions in the Chicago Public Schools in 1977 being held by Blacks.

However, during the years 1965 to 1977, the percentage of Black students enrolled in the city's public schools increased from perhaps 35% to 57%. Thus, in 1977, the proportion of Black policy makers remained 22% lower than the institution's constituency base.

In February, 1980, the Illinois Department of Mental Health and Developmental Disabilities had a total of 18,902 employees with some 5,046 Black American employees. This accounted for 26.8 percent of the Department's employees. Black Americans constituted 4.9 percent of the Department's oficials/managers; 11.5 percent of the professionals; 29.2 percent of the technicians; and 38.3 percent of the Department's paraprofessional employees.

The Chicago Urban League reviewed over 22,000 policy-making positions in the Chicago area in 1977. This included the State and Federal government, the public and private sectors, voluntary, non profit agencies and the business, labor and industrial sectors.

Findings are reported in Blacks In Policy-Making Positions in Chicago A Follow-Up Study, Chicago Urban League, Winter 1979.

Generally, it was found that Blacks had gone from 2.7 percent of all policy-makers in 1965 to 3.8 percent in 1977. This 1.1 percent increase occurred over a time when Blacks in Cook County (mainly Chicago) rose from approximately 20 percent to more than 28 percent of the population.

Blacks gaining access to a middle-class lifestyle may have increased somewhat, however, the mechanisms which influence the quality of community life continue to remain almost completely in the control of Whites.

Blacks, during the period 1965 to 1977, did not gain more clout in the decision-making process which might in turn have an impact on Blacks as a whole. In reviewing the record of White-controlled companies in the private domain where most of the policy-making posts exist, it was clear that Blacks continue to face almost complete exclusion.

All of the above demographic factors impinge on the mental health and special education needs and services for Black children and adolescents.

In particular we are focusing on mental health and special education services. Children and adolescents who

have been psychiatrically hospitalized or who are at a high risk of community extrusion because of their actual or potential disordered behavior are the primary clients.

These children and adolescents may be described as psychotic or borderline psychotic; most common diagnoses would be one of the schizophrenias, symbiotic psychosis or major affective disorder. Characteristic symptoms might include severely impaired reality testing and may include hallucinations, delusions, avoidance or withdrawal from human contact, apathy, bizarre behavior, deficient or unusual forms of communication, agitation and/or potential danger to self or others. Significant impairment in several major life functions would be expected.

In the full spectrum of services available from the nospital and residential treatment programs to the less restrictive day treatment, sustaining care and outpatient programs clients with less severe disorders would be served as their needs indicate.

A basic goal of the Illinois Department of Mental Health and Developmental Disabilities is to promote the continued functioning of young people within the community, home, and school, and to reduce extrusion because of

emotional and/or mental problems. Funding is therefore provided for outpatient services specifically directed toward treating persons under age 18 (and their families) who have serious emotional or behavioral disturbance or seriously limited social functioning, and those whose present level of functioning and behavior is so disturbing to the individual or the community that extrusion is likely without intervention by the community mental health system.

Day treatment services are provided for children and adolescents who have been "tuitioned out" of public school attendance because of the severity of their conditions. These youth require intensive mental health treatment and social skills training, without which they are unable to function in their usual community systems, i.e., home neighborhood, school, etc. These services are generally provided within the framework of a school-like setting.

Identifying characteristics of seriously emotionally disturbed children and adolescents have been further stated in Public Law 94-142.

Various administrative techniques, such as decentralization, focusing on community identification of needs and an emphasis on cooperation with other entities in the community have been utilized in providing services.

Within the State of Illinois several counties have been designated by the Department of Mental Health as comprising Region 2. This is an area of 5,100 square miles containing sixty-four percent of the state's total population. For planning and administrative purposes, the region is divided into subregions which contain three or more geographic planning areas. It is the responsibility of subregion staff to coordinate departmental resources within each of its planning areas to meet the needs of each population. Subregion 12 is one such subregion in the City of Chicago.

Subregion 12 comprises the far southside of the City of Chicago. While the population is heterogeneous along many dimensions it is subject to the demographic facts and trends delineated above.

As of the 1970 census, about 700,000 people resided within the area. This included more than 243,000 persons

under the age of eighteen. The 1980 census is expected to show an increase to 1,000,000 and 300,000 respectively. Conservatively speaking, some 30,000 children and adolescents in the area may be in need of various mental health services.

There are Whites and Hispanics or Mexicans residing in Subregion 12. There are many middle class and upper middle class Blacks in the area. Most of these families utilize private health care providers located outside of the subregion. Many send their children to private schools.

However, the majority of the population is Black and of a lower middle to lower socio-economic status. By far, most of the people utilizing public school and public mental health services in the area are Black and of a low socio-economic status.

A characteristic of Subregion 12 has been a lack of stabilized mental health or human service programs. This has occurred because much of the area has undergone racial and economic changes in the past two decades. These changes have been such that were likely to produce stress on families and individuals, thus creating a need for the very services that were lacking.

Basically, during the late 1950's, 1960's and early 1970's when some funds were being provided for new mental health, educational and human service programs, Subregion 12 was not targeted for extensive development in those areas.

During that time, the primarily White middle class population of Subregion 12 was moving out to the suburbs and other locations. As they left, their churches, hospitals, service organizations, businesses, etc. left with them or closed down.

While the Blacks that moved in were heterogeneous in many respects, many were low income or middle class only as long as everyone in the family of age worked, and one or two paychecks weren't missed. Moreover, the number of public aid recipients in the area has continued to increase.

These population changes began when most funds for development were going to other areas. Now that funding for new programs has been restricted, the area of Chicago with the largest Black population has the fewest established health and human service provider institutions.

The Department of Mental Health has attempted to assist in meeting the needs of the area through its

Grant-in-Aid program. This program provides funds to community-based agencies or organizations to provide mental health services. One goal is to integrate these programs into a continuum of services encompassing mental hospital facilities, residential treatment programs, and a range of helping agencies in the community that aid in total treatment and rehabilitation plans.

For fiscal year 1981, the Illinois Department of Mental Health and Developmental Disabilities awarded some $1,011,648.00 to child and adolescent mental health programs in Subregion 12.

These funds went to provide psychotherapeutic services at four outpatient programs, six day treatment programs and contributed to the budgets for sustaining care services at five Chicago Board of Health Mental Health Centers.

Generally, these Grant-in-Aid agencies receive additional funding and/or in-kind contributions from other sources. For example, the six day treatment programs funded by DMH/DD receive half or more of their budgeted funds from the Illinois State Board of Education and the local school district. For fiscal year 1981,

this amounted to some $1,094,033.

There are some other private schools in the area that do not receive grants from DMH/DD for clinical services but do receive special education funds for serving emotionally disordered children. This necessitates collaboration with the outpatient treatment programs.

Additionally, a new federally funded comprehensive mental health center started providing services in the subregion during FY81. This center has a major focus on services for children and adolescents.

During the period July 1979, through June, 1980 these DMH/DD Grant-in-Aid programs provided direct diagnostic and psychotherapeutic treatment services to thirteen hundred ninety-one children and adolescents.

Only one private hospital in the subregion has psychiatric beds. The unit primarily serves adults and a few older adolescents. It has fourteen psychiatric beds. This same private hospital has the busiest emergency psychiatric room in the City of Chicago.

Some of the children and adolescents in Subregion 12

who require psychiatric hospitalization have insurance coverage and go to private hospitals outside of the subregion. Others have medicaid and go to private hospitals. However, medicaid pays for only twenty days of inpatient psychiatric services. Therefore, the majority must use the state hospital.

The state inpatient facility that serves Subregion 12 is the largest public or private funded inpatient program for severely emotionally disturbed children and adolescents in the State of Illinois, (152 inpatient beds and a 50 patient day treatment program operated in collaboration with the Chicago Public Schools). This facility is located some twenty seven miles from most points within Subregion 12.

The catchment area of this state hospital includes the full range of ethnic and socio-economic groups in urban, suburban and rural areas.

Subregion 12 makes up about 15 percent of the population served by this state hospital. However, during the period July 1978 through December 1979 children and adolescents from Subregion 12 made up twenty three percent of the admissions into the program.

Available admissions data at this facility seem to show the primarily Black south side of Chicago as having approximately three times as many per capita severely emotionally disturbed children and adolescents as the rest of the catchment area served by the facility.

Moreover, it appears that the majority of south side referrals to the program have been of the acute cr crisis nature. These referrals are usually acutely psychotic, suicidal, assaultive, etc., with a long history of problems and all too often a short history of any significant involvement in outpatient treatment.

Many of these children and adolescents had not been in treatment at the community based Grant-in-Aid programs prior to hospitalization. This points to the need for early identification, outreach, community education, and collaboration between mental health and other service providers.

During the school year, the Chicago PUblic School System has had some nineteen public school classrooms in the area designated for serving the educational needs of seriously emotionally disordered children and

adolescents. Generally, these classrooms were provided with school psychological and social work services. However, attempts have been made to collaborate with the public mental health programs for clinical treatment services. These classrooms serve some one hundred twenty one children and adolescents.

Some 452 children in the area have been placed in the less restrictive Early Remediation Approach self-contained public school classes for children with behavioral disorders. Approximately 154 adolescents have been placed in the high school level version of the same program.

Approximately twelve hundred children and adolescents in the area have been "tuitioned out" of public school enrollment because of the severity of their condition. Many of these youth attend the day treatment and private school programs mentioned previously.

As stated earlier, a major thrust of DMH/DD is to maintain and treat children and adolescents in their own communities. Thus, a service delivery system, based upon collaboration with other agencies and the development of community owned and operated services is emphasized.

The subregion office attempts to serve as an integrating force, defining needs, filling gaps, collaborating, consulting and establishing organizational relationships. The subregion seeks to coordinate services, thus ensuring continuity of care.

Collaboration is essential given the complexities involved in dealing with the demands of a child or adolescent's disorder. Appropriate care must be provided in light of numerous factors including developmental needs, importance of group and peer relationships, importance of cognitive issues and educational experiences, relative dependence on adults, family/social status, and the need for children to receive repeated recognition for accomplishments and strengths.

Because of the complex developmental and current life factors contributing to children's problems, the most important ingredients of treatment quite often are the coordination and long-term continuity of services.

Children require a spectrum of services. They include outpatient, inpatient, emergency, day treatment, consultation, and community education. Additionally,

interdisciplinary teams are necessary to meet the health, legal, educational and social needs of emotionally disturbed children.

It must be recognized that no facility that provides mental health or special education services to children and adolescents can operate effectively in isolation. Each one must concentrate on offering one or more of the total range of services needed and coordinate its efforts with those of others that take the responsibility for providing services.

Only where a full range of services is available can individual facilities operate effectively to offer children and families specific services to meet their needs at a given moment.

The spectrum of services is often described by conceptualizing a three-echelon model: the first echelon would offer early, often emergency treatment and primary prevention, as close as possible to the precipitating events; in the second echelon would be found longer term, more intensive treatment, and finally, the third echelon would offer special kinds of treatment, often quite complex and long term such as in psychiatric hospitals or

residential treatment centers.

The majority of the mental health and special education services available in Subregion 12 are of the second echelon type and to a lesser degree the third echelon type. Basically, the major functions of the programs are to diagnose and treat or provide appropriate education for children and adolescents and families with mental health or emotional problems.

Agencies must develop working relationships with other service providers. They must be expected to provide evidence of assured and appropriate linkage; membership in active inter-agency organizations; record and data exchange systems; designated liaison staff between agencies; and working letters and agreements.

Implementation of the above practices would help to eliminate the tendency for children to get caught in a cobweb of often conflictual service agencies. These techniques would help stop the debilitating experience of having to run around from agency to agency looking for appropriate services. Referral to one agency in the network should automatically mean that other appropriate service

providers are available to the client.

Underlying such a network must be a central treatment team philosophy that views each child as the responsibility of the community, rather than of a single agency. The basic philosophy must entail relating the needs of a given child or adolescent to the resources embodied in an agenc- or agencies, rather than to relate the resources of the given agency to the multiple needs of a client.

Obviously, a crucial element in the above is personal contact and involvement between agency workers. Mutual trust must be established. Agencies must come to feel comfortable with their own programs in order not to be unduly defensive, or afraid that they will be criticized if they share information and resources instead of blaming other agencies for percieved failures with clients.

Funding agencies must be careful that their policies do not foster undue competition between agencies and thus hinder real cooperation and continuity of services for children and adolescents.

The emphasis of Public Law 94-142 and various state regulations on comprehensive assessment, individualized

planning, and multidisciplinary input provides an excellent avenue for implementation of the central treatment team philosophy referred to earlier.

As a child becomes known to the special education staff, clinical and educational planning responsibility can be assigned to a specific case manager or designated advocate. This person would be responsible for pulling together the various mental health and other service providers in the network who might be able to meet some of the needs of the child. This must include the families and possibly other people not ordinarily regarded as mental health workers.

The primary consideration of this team would be the establishment of an individually tailored comprehsive treatment and education program based upon the child's family, school, and community.

It is through working out and implementing such individualized plans that agency representatives begin to feel comfortable with sharing information and trust between agencies develops. The basic idea or feeling of a community or group responsibility for the child grows. This in turn leads to more interagency cooperation, appropriate

services received when needed and helps to ensure continuity of services for children and adolescents.